

♥ APPLICATION ♥

- ☐ Summer Deaf Camp June 15-21, 2014
☐ Summer Skills Program July 13-19, 2014 (Blind and Visually Impaired)
(check one please)

1. Name: _____
2. Address: _____ Zip: _____
3. Age: _____ Male: _____ Female: _____ Birth Date: _____
4. Parent/Guardian's Name: _____

AUTHORIZATION FOR TREATMENT

Student Name: _____

In case of illness and/or injury, permission is granted to treat the above named student at the Montana School for the Deaf and the Blind Summer Program, and make necessary referrals to outside physicians and facilities for treatment.

Parent/Guardian Signature

Date

I do authorize the dispensation of daily prescription drugs. My child is currently taking _____ medication and must receive it _____ times per day. The camp coordinator(s) will dispense all medications. Additional comments:

Parent/Guardian Signature

Date

I do authorize the dispensation of non-prescription, over the counter drugs, such as Tylenol, Pepto-Bismol, cough syrup, etc. Please list any exceptions:

Parent/Guardian Signature

Date

GENERAL HEALTH INFORMATION

There is the remote possibility some child might have a reaction. The organizers cannot be responsible if all safety precautions are taken, i.e., checking for previous allergies. **PLEASE LIST ANY ALLERGY HISTORY (INCLUDING FOOD, ENVIRONMENT, AND MEDICATION ALLERGIES):**

List childhood communicable diseases your child has had:

List recent infections and chronic illnesses, such as frequent ear infections or asthma, your child has had:

List previous surgeries:

Are immunization up to date? _____ Date of last diphtheria-tetanus booster? _____

Current health status: _____

Glasses: Yes _____ No _____

Contact Lenses: Yes _____ No _____

Hearing Aids: Yes _____ No _____ Model _____ # _____

T-shirt size: Youth S M L Adult S M L XL XXL (Please circle one)

AUTHORIZATION FOR EMERGENCY SURGERY

We hereby authorize the Superintendent (or his designee), of the Montana School for the Deaf and the Blind to use his best judgment and act in our stead by authorizing emergency surgery for our child while in attendance at the Montana School for the Deaf and the Blind Summer Program, should sudden illness or injury occur and such surgery be deemed necessary by the attending physician.

Before exercising this authorization, the Superintendent (or his designee), is to make every reasonable attempt to contact us in due time and is to consult with the physician or physicians concerning the urgency of the surgery.

Father's Signature

Date

Mother's Signature

Date

Parent's Address(es) : _____

Home Phone: _____ Work Phone: _____

Health Insurance Company: _____
Number: _____

Child's Social Security # _____

Please list two (2) people who we can contact in any emergency if you are not immediately available:

_____ Phone: _____ Relationship: _____

_____ Phone: _____ Relationship: _____

Please enclose a copy of your child's Medicaid Card (if applicable)

PERSONAL RELEASE FORM

Student Name: _____

The directors, agents and employees of the Montana School for the Deaf and the Blind are hereby released, acquitted and discharged from any claim for damage or suit by reason of injury, illness or damage to person or property during the course of this program including transportation to or from any event, and in that regard, I hereby covenant that on my behalf and/or the above named not to file a claim or bring suit with respect to any such injury or damage.

I, the undersigned, am Parent/Guardian of the specified person. I have read and fully understand the provisions of the above release and have explained them to that person. I hereby agree that I and said person will be bound thereby, and shall defend you and hold you harmless for a disaffirmation thereof by said person.

Signature

Date

PICTURE (MEDIA) RELEASE

I do/do not (circle one) give permission for my child to be specifically interviewed or photographed by newspaper, TV, radio or other media personal while participating in the Summer Program at the Montana School for the Deaf and the Blind. This may include the MSDB WebSite and/or Newsletter.

Signature

Date

CODE OF CONDUCT

I acknowledge that alcohol, drugs, sexual misconduct or illicit behavior on the part of the participant are grounds for expulsion during the summer program. I further agree that participants expelled from the summer program for any reason will return home on the first available public transportation at their parent/guardian's expense.

Signature of Parent/Guardian

Date

Signature of Participant

Date